PEORIA public schools

Where remarkable happens every day

Parent/Guardian Contact Information

Name: _____ Relationship to student: _____

Address: _____

Cell phone number: _____ Home phone number: _____

Emergency Contact Information

Name: _____ Relationship to student: _____

Day phone number: _____ Evening phone number: _____

Cell phone number: _____

Health Insurance Information

Provider: _____

Policy Number/Group Number: _____

To be read and signed by the student and parent/guardian of the named student:

1. I am the parent/guardian of the below named student and give my permission for my child or ward to participate in the interscholastic sport(s) or intramural athletics indicated. I have read the *Extracurricular Handbook* and understand its terms.
2. I acknowledge having read and received the attached *Concussion Information Sheets*.
3. I acknowledge having read and received the attached *IHSA Steroid Testing Policy.*
4. I acknowledge having read and received the *PPS District 150 Athletic Code.*
5. I understand that all sports can involve many **risks of injury**, and I understand that the degree of danger and seriousness of risk vary significantly from one sport to another with contact sports carrying the higher risk. I am aware that participating in sports involves travel with the team. In consideration of the School District permitting my child to participate, I agree to hold the District, its employees, agents, coaches, Board members and volunteers harmless from any and all liability, actions, claims or demands of any kind and nature whatsoever that may arise by or in connection with the participation of my child in the sport(s) or athletics. I assume all responsibility and certify that my child is in good physical health and is capable of participation in the above indicated sport or athletics.

_____
Student Name (Print)

_____ Date _____
Student Signature

_____ Date _____
Parent/Guardian/Custodian Signature

_____ _____ _____
Parent/Guardian/Custodian Name (Print) Home Phone Work Phone

District 150 School Copy

IHSA Sports Medicine Acknowledgement & Consent Form

Acknowledgement and Consent

Student/Parent Consent and Acknowledgements
By signing this form, we acknowledge we have been provided information regarding concussions and the IHSA Performance-Enhancing Testing Policy. We also acknowledge that we are providing consent to be tested in accordance with the procedures outlined in the IHSA Performance-Enhancing Testing Policy.

STUDENT

Student Name (Print): _____ Grade (9-12) _____

Student Signature: _____ Date: _____

PARENT or LEGAL GUARDIAN

Name (Print): _____

Signature: _____ Date: _____

Relationship to student: _____

Consent to Self Administer Asthma Medication

As a patient under my care, _____, is prescribed to self-administer the following asthma medication.

Medication_____

Purpose_____

Dosage_____

Time/Special Circumstances_____

_____

_____ _____ _____
Printed Name of Physician **Signature of Physician** **Date**

I, _____, do hereby give my son/daughter, _____,
Permission to self-administer his/her asthma medication as prescribed by his/her physician during athletic competition.

_____ _____ _____
Printed Name of Parent/Guardian **Signature of Parent/Guardian** **Date**

Each year IHSA member schools are required to keep a signed Acknowledgement and Consent form and a current Pre-participation Physical Examination on file for all student athletes.

GREAT PLAINS
ORTHOPAEDICS
303 N. WM. Kumpf Blvd. Peoria, IL 61605
309.676.5546 309.676.5045 fax
www.greatplainsortho.org

Patient/Athlete Name (Printed): _____ **Date:** _____

Consent to Treat

I hereby authorize the sports medicine staff from Great Plains Orthopaedics to evaluate and treat my student athlete's injury/illness pursuant to their Licensure and Scope of Practice. This includes any and all reasonable and necessary preventative care, treatment, and rehabilitation for these injuries/illnesses. In addition, in the event my student athlete needs emergent treatment/care, I authorize Great Plains Orthopaedics sports medicine staff to arrange for such care, including transportation if appropriate. I understand I will be contacted as soon as possible by the Great Plains Orthopaedics sports medicine staff in the event my child has an emergent injury/illness.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been furnished with a copy of the Notice of Privacy Practices of Great Plains Orthopaedics. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I understand that Great Plains Orthopaedics has reserved a right to make changes to the privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available upon request.

Authorization Form for Release of Confidential Health Information

I hereby authorize Great Plains Orthopaedics to release to: Peoria Public Schools (or its agents) the following information contained in the patient record of

Patient/Athlete Name (Printed): _____ **Date of Birth** _____

The purpose of the authorization is to allow Great Plains Orthopaedics to release to the school, or its agents, such private health information as it may deem reasonable regarding the student athlete's injury/illness to include: diagnosis, treatment, rehabilitation, and management. I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law. I understand that Great Plains Orthopaedics may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party. I understand that information used or disclosed pursuant to this authorization is covered under a Business Associate Agreement between the School/School District and Great Plains Orthopaedics which states that both will protect the private health information of the student-athlete. I understand that this authorization is valid until it expires, unless revoked before that. I understand that I may revoke this authorization at any time by giving written notice to Great Plains Orthopaedics of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where Great Plains Orthopaedics has already relied on it to use or disclose my health information. Written revocation must be sent to Great Plains Orthopaedics. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on July 31, 2015.

Patient/Athlete Signature: _____ **Date:** _____

When patient/athlete is a minor, Parent/Guardian signature is required.

Parent/Guardian Signature: _____ **Date:** _____

Please specify your relationship to the patient: _____